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The Partnership Press

Restructuring the Services System Through Regional Partnership Planning

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Community-Based Services: A Promising Return on Reinvestment*

In December 2002 Governor Mark Warner announced a bold agenda to reform the state's public mental health, mental retardation, and substance abuse services system.

The Governor's "Community Reinvestment Initiative" was supported by the Legislature in its 2003 Session. Governor Warner challenged us to expand community-based services that would allow us to reduce state institution beds for adults who were only remaining there because of the lack of community services. The savings would be reinvested locally. We were given bridge funding to build local services that could serve the people currently in the hospital. The Governor's initiative is not about closing state institutions. Statewide $12 million in existing state funds will be reinvested in 2003-04 and expanded to $21.7 million for 2004-05.

Dr. Steven J. Ashby

A significant number of people discharged from the state hospital will be eligible for Medicaid. Consequently, we will be able to serve them plus other high-risk consumers with no additional costs to the state. Those of us in the field welcomed the Governor's challenge. It represented an array of positive elements long sought for by the system. These elements are being addressed very successfully in my Region, which includes 23 localities and extends from New Kent to Goochland counties and from Henrico to Greensville counties. $4.2 million in annualized Reinvestment funds for 2003-04 were identified along with the state living up to its commitment to provide $500,000 in bridge funds. This effort has allowed Central State Hospital to close its first 15 bed Unit this June and make $1.4 million in Reinvestment funds immediately available to the region, with no significant impact on state facility staff.

With reinvested money we are developing and establishing new services such as specialized assisted living/day program services, intensive supportive residential services, psychosocial rehabilitation programs, assertive community treatment services, intensive case management, clinical services for those with co-occurring mental health and substance abuse disorders, just to name a few. New regionally purchased specialized nursing care services are now also in development.

A new type of innovative regional care, 24/7 supervised residential crisis stabilization and detoxification services, not previously available in our region, will be operational through a contracted private sector provider in a matter of several weeks. All regional Reinvestment services and a number of local services are being delivered through private sector providers very willing to serve this challenging consumer population and work with Community Services Boards (CSB), thus further building trust and strengthening the overall community network of care.

Through regional planning, consumers are now being served closer to home. CSB case management, transportation and administrative costs are lower. Access is greater because more time can be spent on direct service to and support of the consumer and family. Reinvestment is working in our region because innovative care has been established through state funding. It is also working because all responsible parties have made a determined effort to take collective ownership and accept collective accountability for its success and maintain focus on its primary goal which is providing the best and most appropriate care possible to its consumers and their families in a cost effective and consumer outcome effective manner. Critical to continued success is the vigilance of all involved parties in continuing to educate and communicate with advocates, local government, professional and provider groups, public agencies, etc. regarding our goals, our plans, our progress, and our outcomes, seeking input all along the way.

Reinvestment is beginning to accomplish the primary objectives included in the final Report submitted to President Bush in July by the President's New Freedom Commission on Mental Health. As stated in the Report unmet needs and barriers to care include "fragmentation and gaps in care for adults with serious mental illness". The Report goes on to say "more individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs". The Report also adds that " the Nation must replace unnecessary institutional care with efficient, effective community services that people can count on".

Reinvestment is not a substitute for the larger system issues of major under-funding in the face of ever growing and complex consumer and family need. If Reinvestment can work then imagine what the system could do if it had the additional funds in the system it so desperately needs to more adequately serve all the age and disability populations it is responsible for. To the Governor we say thank you for the opportunity. To the Legislature we say thank you for your support. We hope you and the public are encouraged by this initial positive return on your Reinvestment.

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Regional Updates

Central Region

Regional Activities: The Central Region has achieved a number of successes over the past month. In June, Central State Hospital closed its first 15-bed unit, with DMHMRSAS transferring $1.4 million in July to RBHA as the regional fiscal agent. A second unit was closed in August– almost two months ahead of schedule. The funds from these unit closures will be used to address the Region's planned and budgeted regional and local Reinvestment costs. A comprehensive model Reinvestment Memorandum of Agreement (MOA) was established with the Commissioner and DMHMRSAS. The region also hired a Reinvestment Project Manager who will start on September 1, 2003. The Regional Consortium RFP Committee has finalized the RFP process with negotiations continuing with a selected vendor to establish a regional 24/7 supervised residential crisis stabilization/detox program with services available in October. In addition, the region is following up with potential providers of regional specialized nursing care services for identified CSH patients in need of such care. Initial contracting will be on a purchase of service basis. The region is continuing to develop and/or expand upon local services, such as: intensive case management, psychosocial rehab, assertive community treatment, intensive supportive residential, and specialized assisted living with day program. The Regional Partnership Planning Steering Committee has agreed to hold 6 stakeholder-invited Focus Groups and 2 Public Hearings in September. Focus Groups will cover mental health, mental retardation, substance abuse, local government, hospitals/providers, and criminal/ juvenile justice discussions. These events will utilize resource information already secured through regional consumer populations/gaps survey, a demographics/prevalence study and a report provided by the Central Virginia Health Planning Agency (CVHPA).

Northwestern Area

Regional Activities: The reinvestment strategy for HPR I is well underway. Fifty-four individualized discharge plans have been approved. There are plans to have approximately 26 people discharged by the end of the first quarter, closing the first ward at Western State Hospital. Bridge funds will be used to fund these plans until the release of savings from the unit closing.

Unfortunately, the region did not get a waiver for the Certificate of Public Need process for the planned development of an ICF/MR. Therefore, the vendor will be submitting an application by the end of August. Once it is approved, the vendor will need approximately three months before it can be fully operational. It is too early to tell when the six residents will be discharged to that facility.

The region held a partnership-planning meeting July 11th in Culpeper. A vision statement and regional services have been identified and approved by the group. At this meeting, there was a good deal of discussion about acute care beds. As a result, a sub-group was formed to discuss this issue. This group will meet August 15 at 10:00 a.m. at RRCSB in Culpeper.

Reinvestment discussions will continue after the Regional Executive Directors meeting, September 19, 2003. The Executive Directors will meet at 10:30 a.m. at RRCSB in Culpeper.

Partnership planning will continue in October- date, time and place to be determined.

Eastern Region

Regional Activities: The regional effort includes increased participation by key stakeholder groups, including expansion of the Systems Oversight and Planning Group for medical, social work and nursing staff of Eastern State Hospital. Additionally, there is active participation by representatives selected by the regional chapters of the National Alliance for the Mentally Ill– Virginia (NAMI-VA). The planning group developed and distributed a Request for Proposals sent to local providers of inpatient psychiatric care as the first step in shifting acute care from Eastern State to the community; established a Utilization Review process to guide the purchase of local acute care; and developed initial outcome indicators to measure the effectiveness of the project. An ad hoc work group, comprised of Emergency Services Managers, ESH staff, Mental Health Directors and a NAMI-VA advocate is focusing on key issues related to project implementation and the interface with local magistrates. A Regional Authorization Committee comprised of staff from the DMHMRSAS, the nine CSBs and Eastern State Hospital will begin to meet in August to refine guidelines for approving and monitoring admission to local, private facilities. The project plans to fully implement of the shift of acute care in October.

Regional Updates (continued)

Northern Region

www.fairfaxcounty.gov/service/csb/region/partnershipmain.htm

Regional Activities: During June and July, the Northern Region has focused on three major activities. First, and most important, the Region has worked closely with DMHMRSAS to develop and begin implementation of a major Reinvestment Initiative that will transfer the fiscal management of about $2.5 million in State funds from NVMHI to a CSB or other local organization. All other aspects of this highly successful regional project will remain in place. These funds are associated with the Discharge Assistance and Diversion (DAD) Project and have been used since 1996 for private sector bed purchase and to support a range of community based services that help divert admissions to NVMHI or to facilitate discharges. Secondly, the Steering Committee endorsed an application by vaACCESS in collaboration with many public – including both DMHMRSAS and DRS- and private providers in the region to receive a Department of Labor Grant focused on strengthening vocational services. The third major activity is the completion of the initial Regional Report. The Region will submit its report in early August. It will include background material related to population growth, some preliminary observations about the current role of the private sector providers of inpatient psychiatric services and the implications of these factors in the years ahead. It will also identify issues for further study or action at the State level, propose some regional activities such as promoting the Recovery Model and outline the work plan for the next phase of the Regional Partnership planning process. The work of the region continues to be characterized by broad stakeholder involvement. Further information about the activities of the Northern Region may be found at its website.

Far Southwestern Region

Regional Activities: The Transition to Reinvestment Workgroup, a subgroup of the Southwestern Virginia Behavioral Health (SWVBH) Board for Regional Planning, has been meeting almost every other week throughout the spring and summer. This group is composed of the CSB Mental Health Directors for the region, the Director of SWVMHI and Central Office, consumer and family representatives. The first Specialized Stakeholder meeting was held July 25th in Wytheville. Designed to inform and involve the region's State Senators and Delegates, it included a presentation on the current status of planning efforts with an emphasis on regional needs and an update on the MR/MI ICF-MR program being developed on the grounds of SWVTC. Those present were pleased with the interaction and the ability to ask some tough questions.

The new regional MR/MI program was originally a part of "Reinvestment" planning. However, it was determined that the program could generate Medicaid revenue once some startup costs were covered. SWVTC is in the process of hiring staff, rearranging cottages and planning the program. The regional MR/MI Workgroup, which is a standing committee of the SWVBH Board, is screening applicants for the approximately 90 day program which is designed to provide specialized services for some of our most difficult-to-serve MR/MI consumers.

Additional Partnership Planning meetings are scheduled in September around the region. Dates and locations are: Big Stone Gap (Mountain Empire Community College), 9/10; Richlands (Southwest Virginia Community College), 9/11; Blacksburg (New River Valley Community College), 9/15; Wytheville (Wytheville Community College), 9/16; and Abingdon (Higher Education Center), 9/25.

The Transitions Workgroup continues to plan for future Partnership Planning meetings, develop consensus around bed purchase and utilization review activities and hire a Project Manager. Interviews have been held for this exciting new regional position and we hope to hire an excellent candidate in the very near future.

RURAL HEALTH CALENDAR

The Virginia Rural Health Resource Center (VRHRC) serves as a clearinghouse for rural health information. The VRHRC has developed a Rural Health Calendar and welcomes posting of upcoming meetings relevant to rural consumers, health providers, policy makers, educators, and individuals with an interest in rural health. If you would like to post your meetings that are open to the public and related to rural health issues, please send the following information to **redavis@vrhrc.org** : a brief title of the event, description of the event (including date, time, location and contact number or website). The calendar is available at **www.vrhrc.org**.

Regional Updates (continued)

Catawba Region

Regional Activities: The Catawba Regional Partnership's goal is to develop and implement strategies to provide a more efficient, effective and accessible system of care that includes both public and private sector treatment providers without sacrificing inpatient or outpatient treatment capacities.

The Leadership Committee for this project includes: S. James Sikkema, Executive Director of Blue Ridge Behavioral Healthcare; Jack Wood, CEO of Catawba Hospital; Joe Sargeant, Executive Director of Alleghany Highlands CSB; Paula Mitchell, Vice President for Behavioral Healthcare at Lewis-Gale Hospital; Rick Seidel, Director of Clinical Services at Carilion Roanoke Memorial Hospital; June Poe, Member of the Roanoke chapter of the National Alliance for the Mentally Ill; and Diane Kelly, the Executive Director of the Roanoke chapter of the Mental Health Association. Helen Ardan of Blue Ridge Behavioral Healthcare and Walton Mitchell of Catawba Hospital are the staff leaders dedicated to the project.

The Leadership Committee has broken down the overall project into eight priority areas, including:

- Treatment Process across the continuum of care
- Provision of Psychosocial Rehabilitation and Day Treatment services
- Development of Transitional Housing options
- Development of a PACT program for Alleghany-Highlands CSB
- Physician Resource Utilization
- Centralized Pharmacy Services
- Budget and Cost and Revenue Analysis
- Contract Development

The Leadership Committee formed workgroups at their May 30th meeting to address each priority area. Individuals from each of the participating public and private partners as well as advocacy organization partners were appointed to the workgroups to review the existing services and to develop improved processes in their specific area. The Regional Leadership met June 26 and heard presentations from all eight priority area workgroups. The Leadership met June 30 to continue their discussion of the workgroup products.

The Roanoke Chapter of the National Alliance for the Mentally Ill and the Mental Health Association of Roanoke Valley sponsored two Stakeholders Meetings held July 14th and July 17th. 108 citizens attended these meetings. Valuable feedback was received from consumers, family members and professionals after each workgroup presented a summary of their work.

Additionally, the organization of a Regional Child and Family Partnership is currently in progress. The organizational structure, mission statement, goals, objectives and initial general recommendations have been identified; a Steering Committee has been developed and broad membership is being solicited from organizational stakeholders in the community.

Southern Region

Regional Activities: The Southern Regional Partnership Planning Group held a meeting July 24, 2003, at Danville-Pittsylvania Community Services for stakeholders and other interested parties to review a draft of the Regional Plan. The Regional Plan outlines a description of the Region, mission, structure, guiding principles, stakeholder contribution, and service needs and resource requirements. The major thrust of the Plan is to expand the Region's capacity to maximize consumers' abilities to access services or treatment essential to remain in their respective communities. Emphasis is placed upon initiatives for "community capacity expansion" that will provide services as close to the consumer's home as possible. As community services expand, state facility beds will be reserved for individuals requiring the level of safety and intensity of treatment provided by such facilities. Modifications were made to the draft plan as a result of the July 24, 2003, meeting. The Regional Plan will be submitted to DMHMRSAS in August. Dr. Jules Modlinski is the new Chairperson of the Southern Regional Partnership Planning Group.

Restructuring Policy Advisory Committee and Special Population Work Groups

Commissioner Reinhard convened the first meeting of the Restructuring Policy Advisory Committee on June 24th at Henrico Area Mental Health and Mental Retardation Services. The Policy Advisory Committee, comprised of Regional Leadership and advocates from all regions of the Commonwealth, shared regional updates and discussed expectations for the group's work. In addition, the Policy Advisory Committee began planning for Special Population Work Groups that will focus on:

- Child and Adolescent services
- Substance Abuse Services
- Mental Retardation Services
- Gero-Psychiatric services
- Forensic services

MARK YOUR CALENDAR!

The next meeting of the Restructuring Policy Advisory Committee will be on **September 22nd** at Woodrow Wilson Rehabilitation Center in Staunton.

The purpose of the work groups and general suggestions for work group activities were discussed. Committee guidance for each work group was also established. Each Special Population Work Group will identify questions, issues and opportunities for the group to explore, including best practices and service models. The Policy Advisory Committee brainstormed ideas to assist each work group, including resources available to the various work groups, composition of each group, potential work group members and potential leadership for the groups. These work groups will consider incentives, disincentives, services needs, collaborative opportunities, previously made recommendations, data that describes special needs or identifies specific challenges in serving the special population and will explore the potential for enhancing current models of care through the use of national/state/regional best practices.

The Special Population Work Groups will ultimately make recommendations for consideration by the Regional Partnership Planning Committees and the Restructuring Policy Advisory Committee. Short and long term recommendations will be made to identify policy, legislation, administrative, funding and service development actions that may enhance service systems for special populations consumers. Short term recommendations will be made in August 2003 and long term recommendations will be made in August 2004.

Special Population Work Groups

The Special Population Work Groups are still forming and establishing leadership. Below is the information currently available regarding the establishment of these groups. Additional information will be included in future issues of the Partnership Press.

- **Child and Adolescent Population Work Group:** Convened its first meeting on August 8th in Charlottesville. A second meeting is planned for August 28th. Work Group Leadership: James Martinez, Barb Shue, Don Roe.
- **Substance Abuse Population Work Group:** Convened for the first meeting on August 11th. Work Group Leaders: Robert L. Johnson, Lee Gardner. Work Group Membership includes 19 individuals from various state and local agencies and organizations.
- **Mental Retardation Population Work Group:** Will convene its first meeting September 4th in Henrico. Work Group Leaders: Mark Diorio, Ph.D., Judy Rossi.
- **Gero-Psychiatry Population Work Group:** Convened its first meeting on August 12th at Piedmont Geriatric Hospital in Burkeville. Work Group Leadership: Will Pierce, Dr. Robert Lewis.
- **Forensic Population Work Group:** Will convene for its first meeting on August 21st from 10:00am-2:00pm at Central Office. Work Group Leadership: James Morris, Ph.D., Jeff Feix, Ph.D., Steven Ashby, Ph.D. Work group members include DMHMRSAS, CSBs, VA Supreme Court, criminal justice representatives, private practitioners and other members.

President's New Freedom Commission on Mental Health

Vision Statement: We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community.

In February 2001, President George W. Bush announced his New Freedom Initiative to promote increased access to educational and employment opportunities for people with disabilities. The Initiative also promotes increased access to assistive and universally designed technologies and full access to community life. Not since the Americans with Disabilities Act (ADA) - the landmark legislation providing protections against discrimination - and the Supreme Court's *Olmstead v. L.C.* decision, which affirmed the right to live in community settings, has there been cause for such promise and opportunity for full community participation for all people with disabilities, including those with psychiatric disabilities.

On April 29, 2002, the President identified three obstacles preventing Americans with mental illnesses from getting the excellent care they deserve: 1) stigma that surrounds mental illnesses, 2) unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance, and 3) the fragmented mental health service delivery system.

The President's New Freedom Commission on Mental Health (called *the Commission* in this report) is a key component of the New Freedom Initiative. The President launched the Commission to address the problems in the current mental health service delivery system that allow Americans to fall through the system's cracks.

In his charge to the Commission, the President directed its members to study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements that the Federal govemment, State governments, local agencies, as well as public and private health care providers, can implement. Executive Order 13263 detailed the instructions to the Commission.

The Commission's findings confirm that there are unmet needs and that many barriers impede care for people with mental illnesses. Mental illnesses are shockingly common; they affect almost every American family. They can occur at any stage of life, from childhood to old age. No community is unaffected by mental illnesses; no school or workplace is untouched.

President Bush said,

"... Americans must understand and send this message: mental disability is not a scandal - it is an illness. And like physical illness, it is treatable, especially when the treatment comes early."

Over the years, science has broadened our knowledge about mental health and illnesses, showing the potential to improve the way in which mental health care is provided. Far too often, treatments and services that are based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity. Many recent documents, publications and research findings provide insight into the importance of mental heath, particularly as it relates to overall health.

Mental Illness is a serious public health challenge and is under-recognized as a public health burden. In addition, one of the most distressing and preventable consequences of undiagnosed, untreated, or under-treated mental illnesses is suicide. In addition to the tragedy of lost lives, mental illnesses come with a devastatingly high financial cost. In the U.S., the annual economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount - approximately $63 billion - reflects the loss of productivity as a result of illnesses. Mental health expenditures are predominantly publicly funded at 57%, compared to 46% of overall health care expenditures.

The Current Mental Health System Is Complex

In its *Interim Report to the President*, the Commission declared, "... the mental health delivery system is fragmented and in disarray ... lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration." The report described the extent of unmet needs and barriers to care, including: fragmentation and gaps in care for children, fragmentation and gaps in care for adults with serious mental illnesses, high unemployment and disability for people with serious mental illnesses, lack of care for older adults with mental illnesses, and lack of national priority for mental health and suicide prevention.

The *Interim Report* concluded that the system is not oriented to the single most important goal of the people it serves - the hope of recovery. State-of-the-art treatments, based on decades of research, are not being transferred from research to community settings. In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs. The Commission recognizes that thousands of dedicated, caring and skilled providers staff and manage the service

President's New Freedom Commission on Mental Health (continued)

delivery system. The Commission does not attribute the shortcomings and failings of the contemporary system to a lack of professionalism or compassion of mental health care workers. In short, the Nation must replace unnecessary institutional care with efficient, effective community services that people can count on. It needs to integrate programs that are fragmented across levels of government and among many agencies.

To improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America. The goals of this fundamental change are clear and align with the direction that the President established.

The Goal of a Transformed System: Recovery

To achieve the promise of community living for everyone, new service delivery patterns and incentives must ensure that every American has easy and continuous access to the most current treatments and best support services. Advances in research, technology, and our understanding of how to treat mental illnesses provide powerful means to transform the system. In a transformed system, consumers and family members will have access to timely and accurate information that promotes learning, self-monitoring, and accountability. Health care providers will rely on up-to-date knowledge to provide optimum care for the best outcomes.

When a serious mental illness or a serious emotional disturbance is first diagnosed, the health care provider - in full partnership with consumers and families - will develop an individualized plan of care for managing the illness. This partnership of personalized care means basically choosing *who*, *what*, and *how* appropriate health care will be provided: choosing which mental health care professionals are on the team, sharing in decision making, and having the option to agree or disagree with the treatment plan.

The highest quality of care and information will be available to consumers and families, regardless of their race, gender, ethnicity, language, age, or place of residence. Because recovery will be the common, recognized outcome of mental health services, the stigma surrounding mental illnesses will be reduced, reinforcing the hope of recovery for every individual with a mental illness.

Successfully transforming the mental health service delivery system rests on two principles: services and treatments must be consumer and family centered and care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience. Built around consumers' needs, the system must be seamless and convenient.

Transforming the system so that it will be both consumer and family centered and recovery-oriented in its care and services presents invigorating challenges. Incentives must change to encourage continuous improvement in agencies that provide care. New, relevant research findings must be systematically conveyed to front-line providers so that they can be applied to practice quickly. Innovative strategies must inform researchers of the unanswered questions of consumers, families, and providers. Research and treatment must recognize both the commonalities and the differences among Americans and must offer approaches that are sensitive to our diversity. Treatment and services that are based on proven effectiveness and consumer preference - not just on tradition or outmoded regulations - must be the basis for reimbursements.

The Nation must invest in the infrastructure to support emerging technologies and integrate them into the system of care. This new technology will enable consumers to collaborate with service providers, assume an active role in managing their illnesses, and move more quickly toward recovery.

The Commission identified the following six goals as the foundation for transforming mental health care in America. The goals are intertwined. No single step can achieve the fundamental restructuring that is needed to transform the mental health care delivery system. Achieving these goals will transform mental health care in America.

Note: Article reprinted as excerpt from complete New Freedom Commission Report available online at: http://www.mentalhealthcommission.gov

In a transformed Mental Health System …

- **Goal 1** **Americans Understand that Mental Health Is Essential to Overall Health.**
- **Goal 2** **Mental Health Care Is Consumer and Family Driven.**
- **Goal 3** **Disparities in Mental Health Services Are Eliminated.**
- **Goal 4** **Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.**
- **Goal 5** **Excellent Mental Health Care Is Delivered and Research Is Accelerated.**
- **Goal 6** **Technology Is Used to Access Mental Health Care and Information.**

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